FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022863

Facility Name: CRESTWOOD TERRACE

Address: 13304 S. CENTRAL (Number) CRESTWOOD (City) 60445 (Zip Code)

County: COOK

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

IDPA ID Number: 36-2883290

Date of Initial License for Current Owners: 10/01/76

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) GENERAL PARTNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	126	Intermediate (ICF)	126	45,990	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	126	TOTALS	126	45,990	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	38,557	3,906	762	43,225	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,557	3,906	762	43,225	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.99%

D. How many bed-hold days during this year were paid by Public Aid?
1,045 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	120,891	12,248	5,940	139,079		139,079		139,079			1
2	Food Purchase		163,374		163,374		163,374	(884)	162,490			2
3	Housekeeping	108,079	14,063		122,142		122,142		122,142			3
4	Laundry	45,872	16,416		62,288		62,288		62,288			4
5	Heat and Other Utilities			88,292	88,292		88,292	360	88,652			5
6	Maintenance	7,816	13,176	28,220	49,212		49,212	(1,361)	47,851			6
7	Other (specify):*			8,343	8,343		8,343	25	8,368			7
8	**TOTAL General Services**	282,658	219,277	130,795	632,730		632,730	(1,860)	630,870			8
	B. Health Care and Programs											
9	Medical Director			5,400	5,400		5,400		5,400			9
10	Nursing and Medical Records	1,032,318	41,447	8,080	1,081,845		1,081,845		1,081,845			10
10a	Therapy	38,436		4,220	42,656		42,656		42,656			10a
11	Activities	90,136	1,579	816	92,531		92,531		92,531			11
12	Social Services	41,550		2,009	43,559		43,559		43,559			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,202,440	43,026	20,525	1,265,991		1,265,991		1,265,991			16
	C. General Administration											
17	Administrative	64,008		284,750	348,758		348,758	(260,363)	88,395			17
18	Directors Fees											18
19	Professional Services			42,896	42,896		42,896	5,782	48,678			19
20	Dues, Fees, Subscriptions & Promotions			19,850	19,850		19,850	(5,374)	14,476			20
21	Clerical & General Office Expenses	85,761	13,676	128,693	228,130		228,130	(92,213)	135,917			21
22	Employee Benefits & Payroll Taxes			205,394	205,394		205,394	(1,460)	203,934			22
23	Inservice Training & Education			1,012	1,012		1,012	24	1,036			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			11,042	11,042		11,042	453	11,495			25
26	Insurance-Prop.Liab.Malpractice			62,564	62,564		62,564	606	63,170			26
27	Other (specify):*							3,976	3,976			27
28	**TOTAL General Administration**	149,769	13,676	756,201	919,646		919,646	(348,569)	571,077			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,634,867	275,979	907,521	2,818,367		2,818,367	(350,429)	2,467,938			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: CRESTWOOD TERRACE **#0022863** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,940	
	REPAIRS & MAINTENANCE		0	
			0	5,940
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		45,798	
	ELECTRICITY		28,631	
	WATER		13,282	
	CABLE TV - LOBBY		581	
			0	88,292
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		5,425	
	PAINTING & DECORATING		9,082	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		10,869	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,957	
	FIRE SERVICE		887	
			0	
			0	
			0	28,220
7	**OTHER**			
	SCAVENGER		4,359	
	SECURITY SERVICE		3,984	8,343
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	5,400	5,400

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	4,780	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL		3,300	
			0	8,080
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	2,550	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	1,670	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	4,220
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	816	
			0	816
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	2,009	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	2,009
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number CRESTWOOD TERRACE **#0022863** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	284,750	284,750
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	13,791	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	29,105	
			0	42,896
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	1,698	
	EMPLOYEE WANT ADS	XIX F	2,763	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	8,990	
	LICENSES & PERMITS	XIX F	2,344	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,940	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	200	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,415	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	19,850
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		79,774	
	PENALTIES / OVERDRAFT CHARGES	VI 18	4,225	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		16,083	
	MESSENGER SERVICE		0	
	STAFF DEVELOPMENT		28,611	128,693

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	125,069	
	UNEMPLOYMENT COMPENSATION	XIX D	20,314	
	WORKERS COMPENSATION INSURANCI	XIX D	36,949	
	HOSPITALIZATION INSURANCE	XIX D	15,640	
	EMPLOYEE BENEFITS - OTHER	XIX D	170	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	1,460	
	PENSION/PROFIT SHARING PLANS	XIX D	5,792	
	CHICAGO HEAD TAX	XIX D	0	205,394
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,012	1,012
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		11,042	11,042
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		62,564	62,564
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 907,521

Facility Name & ID Number CRESTWOOD TERRACE #0022863 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			38,322	38,322		38,322	643	38,965			30
31	Amortization of Pre-Op. & Org.			696	696		696		696			31
32	Interest			131,045	131,045		131,045	(55,871)	75,174			32
33	Real Estate Taxes			236,324	236,324		236,324	1,857	238,181			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			33,774	33,774		33,774	3,386	37,160			35
36	Other (specify):* **OFFICE RENT**			9,828	9,828		9,828	(9,828)				36
37	**TOTAL Ownership**			449,989	449,989		449,989	(59,813)	390,176			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			68,985	68,985		68,985		68,985			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			68,985	68,985		68,985		68,985			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,634,867	275,979	1,426,495	3,337,341		3,337,341	(410,242)	2,927,099			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(492)	30		9
10	Interest and Other Investment Income	(57,364)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(884)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(200)	20		17
18	Fines and Penalties	(4,225)	21		18
19	Entertainment		20		19
20	Contributions	(1,915)	20		20
21	Owner or Key-Man Insurance	(1,460)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(1,698)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,940)	20		28
29	Other-Attach Schedule	(32,050)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (102,228)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(308,014)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (308,014)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (410,242)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

CRESTWOOD TERRACE

ID# 0022863

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ (3,439)	6	1
2	STAFF DEVELOPMENT	(28,611)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(32,050)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(884)	0	0	0	0	0	0	0	0	0	0	(884)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	360	0	0	0	0	0	0	0	360	5
6	Maintenance	(3,439)	0	1,503	575	0	0	0	0	0	0	0	(1,361)	6
7	Other (specify):*	0	0	25	0	0	0	0	0	0	0	0	25	7
8	**TOTAL General Services**	(4,323)	0	1,528	935	0	0	0	0	0	0	0	(1,860)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(264,962)	4,599	0	0	0	0	0	0	0	0	(260,363)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	116	5,513	153	0	0	0	0	0	0	0	5,782	19
20	Fees, Subscriptions & Promotions	(5,753)	0	379	0	0	0	0	0	0	0	0	(5,374)	20
21	Clerical & General Office Expenses	(32,836)	4,819	(64,269)	73	0	0	0	0	0	0	0	(92,213)	21
22	Employee Benefits & Payroll Taxes	(1,460)	0	0	0	0	0	0	0	0	0	0	(1,460)	22
23	Inservice Training & Education	0	0	24	0	0	0	0	0	0	0	0	24	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	139	314	0	0	0	0	0	0	0	0	453	25
26	Insurance-Prop.Liab.Malpractice	0	108	426	72	0	0	0	0	0	0	0	606	26
27	Other (specify):*	0	1,536	2,440	0	0	0	0	0	0	0	0	3,976	27
28	**TOTAL General Administration**	(40,049)	(258,244)	(50,574)	298	0	0	0	0	0	0	0	(348,569)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(44,372)	(258,244)	(49,046)	1,233	0	0	0	0	0	0	0	(350,429)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(492)	0	167	968	0	0	0	0	0	0	0	643	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(57,364)	0	0	1,493	0	0	0	0	0	0	0	(55,871)	32
33	Real Estate Taxes	0	0	0	1,857	0	0	0	0	0	0	0	1,857	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	671	2,624	91	0	0	0	0	0	0	0	3,386	35
36	Other (specify):*	0	0	0	(9,828)	0	0	0	0	0	0	0	(9,828)	36
37	TOTAL Ownership	(57,856)	671	2,791	(5,419)	0	0	0	0	0	0	0	(59,813)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(102,228)	(257,573)	(46,255)	(4,186)	0	0	0	0	0	0	0	(410,242)	45

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSULT
				IME REALTY	LINCOLNWOOD	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 274,000	EMI ENTERPRISES		$	$ (274,000)	1
2	V								2
3	V	17	OFFICERS SALARY				9,038	9,038	3
4	V	19	ACCOUNTING FEES				116	116	4
5	V	21	OFFICE EXPENSE				4,819	4,819	5
6	V	25	TRANSPORTATION				139	139	6
7	V	26	INSURANCE				108	108	7
8	V	27	EMPLOYEE BENEFITS				1,536	1,536	8
9	V	35	AUTO LEASE				671	671	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 274,000			$ 16,427	$ * (257,573)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	BOOKKEEPING	$ 79,774	EKS MANAGEMENT		$	$ (79,774)	15
16	V								16
17	V								17
18	V	6	PAINTING/DECORATING				1,503	1,503	18
19	V	7	SCAVENGER				25	25	19
20	V	17	CFO SALARY				4,599	4,599	20
21	V	19	PROFESSIONAL FEES				5,513	5,513	21
22	V	20	WANT ADDS/BACKGR CKS				379	379	22
23	V	21	OFFICE EXPENSE				15,505	15,505	23
24	V	23	SEMINARS				24	24	24
25	V	25	TRANSPORTATION				314	314	25
26	V	26	INSURANCE				426	426	26
27	V	27	EMPLOYEE BENEFITS				2,440	2,440	27
28	V	30	DEPRECIATION				167	167	28
29	V	35	EQUIPMENT RENT				2,624	2,624	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 79,774			$ 33,519	$ * (46,255)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	$ 9,828	IME REALTY		$	$ (9,828)	15
16	V								16
17	V								17
18	V	5	UTILITIES				360	360	18
19	V	6	REPAIR & MAINTENANCE				575	575	19
20	V	19	PROFESSIONAL FEES				153	153	20
21	V	21	OFFICE EXPENSE				73	73	21
22	V	26	INSURANCE				72	72	22
23	V	30	DEPRECIATION				968	968	23
24	V	32	INTEREST				1,493	1,493	24
25	V	33	RE TAX				1,857	1,857	25
26	V	35	STORAGE FEES				91	91	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,828			$ 5,642	$ * (4,186)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BERNARD COHEN	GENERAL PARTN	ADMINISTRATION					MGMT FEE	$ 10,750	17-3	1
2	MORRIS ESFORMES	GENERAL PARTN	ADMINISTRATION					SALARY	9,038	17-7	2
3	AVRUM WEINFELD	CFO						SALARY	4,599	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 24,387		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES
Street Address: 6865 N LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	PATIENT DAYS	884,739	14	$ 185,000	$ 185,000	43,225	$ 9,038	1
2	19	ACCOUNTING FEES	PATIENT DAYS	884,739	14	2,381		43,225	116	2
3	21	OFFICE EXPENSE	PATIENT DAYS	884,739	14	98,637	76,255	43,225	4,819	3
4	25	TRANSPORTATION	PATIENT DAYS	884,739	14	2,845		43,225	139	4
5	26	INSURANCE	PATIENT DAYS	884,739	14	2,209		43,225	108	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	884,739	14	31,442		43,225	1,536	6
7	35	AUTO LEASE	PATIENT DAYS	884,739	14	13,730		43,225	671	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 336,244	$ 261,255		$ 16,427	25

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MGMT
Street Address: 6865 N LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTING/DECORATING	PATIENT DAYS	884,739	14	$ 30,769	$ 30,769	43,225	$ 1,503	1
2	7	SCAVENGER	PATIENT DAYS	884,739	14	510		43,225	25	2
3	17	CFO SALARY	PATIENT DAYS	884,739	14	94,128	94,128	43,225	4,599	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	884,739	14	112,835	83,281	43,225	5,513	4
5	20	WANT ADDS/BACKGR CKS	PATIENT DAYS	884,739	14	7,759		43,225	379	5
6	21	OFFICE EXPENSE	PATIENT DAYS	884,739	14	317,364	288,335	43,225	15,505	6
7	23	SEMINARS	PATIENT DAYS	884,739	14	490		43,225	24	7
8	25	TRANSPORTATION	PATIENT DAYS	884,739	14	6,427		43,225	314	8
9	26	INSURANCE	PATIENT DAYS	884,739	14	8,715		43,225	426	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	884,739	14	49,951		43,225	2,440	10
11	30	DEPRECIATION	PATIENT DAYS	884,739	14	3,418		43,225	167	11
12	35	EQUIPMENT RENT	PATIENT DAYS	884,739	14	53,700		43,225	2,624	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 686,066	$ 496,513		$ 33,519	25

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP
Street Address: 6865 N LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	303,433	14+FACILTY	$ 11,111	$	9,828	$ 360	1
2	6	REPAIR & MAINTENANCE	RENTAL INCOME	303,433	14+FACILTY	17,749		9,828	575	2
3	19	PROFESSIONAL FEES	RENTAL INCOME	303,433	14+FACILTY	4,725		9,828	153	3
4	21	OFFICE EXPENSE	RENTAL INCOME	303,433	14+FACILTY	2,247		9,828	73	4
5	26	INSURANCE	RENTAL INCOME	303,433	14+FACILTY	2,237		9,828	72	5
6	30	DEPRECIATION	RENTAL INCOME	303,433	14+FACILTY	29,895		9,828	968	6
7	32	INTEREST	RENTAL INCOME	303,433	14+FACILTY	46,095		9,828	1,493	7
8	33	RE TAX	RENTAL INCOME	303,433	14+FACILTY	57,331		9,828	1,857	8
9	35	STORAGE FEES	RENTAL INCOME	303,433	14+FACILTY	2,800		9,828	91	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 174,190	$		$ 5,642	25

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LASALLE BANK		X	MORTGAGE	$16,219.00	08/01/95	$ 3,160,000	$ 2,419,456	07/31/15		$ 127,801	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LASALLE BANK		X	LINE OF CREDIT							3,244	6
7												7
8	RELATED PARTY										1,493	8
9	TOTAL Facility Related				$16,219.00		$ 3,160,000	$ 2,419,456			$ 132,538	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,160,000	$ 2,419,456			$ 132,538	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 143,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 188,724	2
3. Under or (over) accrual (line 2 minus line 1).		$ 45,724	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 190,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 236,324	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	136,802	8
1999	132,399	9
2000	135,738	10
2001	141,599	11
2002	188,724	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CRESTWOOD TERRACE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0022863

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-33-307-001-0000	NURSING HOME	$ 188,724.33	$ 188,724.33
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 188,724.33	$ 188,724.33

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,623 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1976	$ 100,000	1
2					2
3	TOTALS			$ 100,000	3

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	126		1976	1971	$ 1,233,000	$	25	$	$	$ 1,233,000	4
5											5
6											6
7											7
8						947		947			8
	Improvement Type**										
9	BUILDING IMPROVEMENTS			8083	24,240					24,240	9
10	BUILDING IMPROVEMENTS			1981	954					954	10
11	BUILDING IMPROVEMENTS			1985	1,000	53	15		(53)	1,000	11
12	BUILDING IMPROVEMENTS			1985	1,884		15			1,884	12
13	BUILDING IMPROVEMENTS			1987	6,130	195	15		(195)	6,130	13
14	BUILDING IMPROVEMENTS			1987	750	24	20	38	14	630	14
15	BUILDING IMPROVEMENTS			1988	64,717	2,054	31.5	2,054		32,483	15
16	BUILDING IMPROVEMENTS			1989	2,985	95	31.5	95		1,358	16
17	BUILDING IMPROVEMENTS			1990	10,962	348	31.5	348		4,699	17
18	BUILDING IMPROVEMENTS			1991	14,001	444	31.5	444		5,506	18
19	BUILDING IMPROVEMENTS			1992	26,640	847	31.5	847		9,723	19
20	BUILDING IMPROVEMENTS			1993	4,065	129	31.5	129		1,381	20
21	BUILDING IMPROVEMENTS			1993	5,035	129	39	129		1,371	21
22	BUILDING IMPROVEMENTS			1994	5,220	134	39	134		1,223	22
23	ROOFING			1995	550	14	39	14		123	23
24	ALUMINUM POLES			1995	5,700	146	39	146		1,247	24
25	ROOFING			1995	10,605	272	39	272		2,278	25
26	FURNACE			1995	764	20	39	20		164	26
27	TILES			1996	9,924	255	39	255		1,930	27
28	BATHROOM IMPROVEMENTS			1997	1,378	35	39	35		220	28
29	NURSE STATIONS			1998	51,911	1,331	39	1,331		7,933	29
30	ROOFING			1999	6,500	167	39	167		746	30
31	DOORS, SCUPPER DRAINS			2000	4,750	172	27.5	172		592	31
32	ALARM/SECURITY SYSTEM			2000	27,728	1,008	27.5	1,008		3,483	32
33	COVE BASE/WALLPAPER			2000	9,250	1,155	20	462	(693)	1,419	33
34	SMOKE DETECTORS			2001	3,571	130	27.5	130		384	34
35	NEW DURO-LAST ROOF			2001	42,450	1,544	27.5	1,544		3,786	35
36	WALLPAPER,BEADBOARD			2001	10,760	391	27.5	391		1,051	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	VINYL FLOORING	2001	$ 3,000	$ 109	27.5	$ 109	$	$ 277	37
38	VINYL FLOORING	2002	3,569	130	27.5	130		190	38
39	HEAT/COOL SYSTEM	2002	1,774	64	27.5	64		93	39
40	FIRE SUPPRESSION SYSTEM	2002	1,874	68	27.5	68		99	40
41	STEEL FIRE DOORS	2003	1,077	18	27.5	18		18	41
42	HEAT/COOL SYSTEM	2003	29,936	498	27.5	498		499	42
43	ASPHALT PAVING	2003	20,049	334	27.5	334		334	43
44	WOOD FLOORING	2003	30,570	510	27.5	510		510	44
45	SHEET METAL	2003	1,000	17	27.5	17		17	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,680,273	$ 13,787		$ 12,860	$ (927)	$ 1,352,975	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 253,466	$ 15,468	$ 24,779	$ 9,311	5 - 10	$ 170,861	71
72	Current Year Purchases	22,760	10,014	1,138	(8,876)	10	1,138	72
73	Fully Depreciated Assets	335,763					335,763	73
74	RELATED PARTY		188	188				74
75	TOTALS	$ 611,989	$ 25,670	$ 26,105	$ 435		$ 507,762	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	2,392,262	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	39,457	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	38,965	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(492)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	1,860,737	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 21,802 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	MAINT/ACTIVITY	03 CHEV EXPRESS VAN	$ 675.85	$ 6,083	17
18				5,889	18
19					19
20					20
21	TOTAL		$ 675.85	$ 11,972	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 353,018	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	417,069		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	70,835		6
7	Other Prepaid Expenses	69,811		7
8	Accounts Receivable (owners or related parties)	777,512		8
9	Other(specify): EMP WAGE ASGN	6,336		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,694,581	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	1,341,750		11
12	Long-Term Investments			12
13	Land	100,000		13
14	Buildings, at Historical Cost	1,233,000		14
15	Leasehold Improvements, at Historical Cost	447,273		15
16	Equipment, at Historical Cost	618,669		16
17	Accumulated Depreciation (book methods)	(1,939,104)		17
18	Deferred Charges	15,657		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,817,245	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,511,826	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 308,062	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	54,991		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,572		31
32	Accrued Real Estate Taxes(Sch.IX-B)	190,600		32
33	Accrued Interest Payable	10,589		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 585,814	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,419,456		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,419,456	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,005,270	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 506,556	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,511,826	$	48

*(See instructions.)

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 575,110	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 575,110	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	160,977	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(229,531)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (68,554)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 506,556	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,442,228	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,442,228	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	57,634	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 57,634	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,499,862	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	632,730	31
32	Health Care	1,265,991	32
33	General Administration	919,646	33
	B. Capital Expense		
34	Ownership	449,989	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	68,985	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,337,341	40
41	**Income before Income Taxes (line 30 minus line 40)****	162,521	41
42	**Income Taxes**	(1,544)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 160,977	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,128	2,168	$ 55,598	$ 25.64	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,330	6,635	144,752	21.82	3
4	Licensed Practical Nurses	11,478	11,790	235,063	19.94	4
5	Nurse Aides & Orderlies	57,776	61,299	514,148	8.39	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,554	3,856	38,436	9.97	8
9	Activity Director					9
10	Activity Assistants	9,999	10,403	90,136	8.66	10
11	Social Service Workers	3,483	3,483	41,550	11.93	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,576	16,444	120,891	7.35	15
16	Dishwashers					16
17	Maintenance Workers	928	992	7,816	7.88	17
18	Housekeepers	15,405	16,307	108,079	6.63	18
19	Laundry	7,381	7,965	45,872	5.76	19
20	Administrator	2,080	2,120	64,008	30.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,095	10,337	85,761	8.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) SEE ATTACHED	4,208	4,248	82,757	19.48	33
34	TOTAL (lines 1 - 33)	150,421	158,047	$ 1,634,867 *	$ 10.34	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 5,940	1-3	35
36	Medical Director	O	5,400	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	4,780	10-3	39
40	Physical Therapy Consultant	L	2,550	10a-3	40
41	Occupational Therapy Consultant	Y	1,670	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	816	11-3	44
45	Social Service Consultant	E	2,009	12-3	45
46	Other(specify) DENTAL		3,300	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 26,465		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KATHLEEN STEEL	ADMIN		$ 64,008
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 64,008

B. Administrative - Other

Description	Amount
EMI ENTERPRISES	$ 274,000
BERNARD COHEN	10,750
TOTAL (agree to Schedule V, line 17, col. 3)	$ 284,750
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		42,896
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 42,896

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 36,949
Unemployment Compensation Insurance		20,314
FICA Taxes		125,069
Employee Health Insurance		15,640
Employee Meals		#REF!
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		170
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		5,792
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		1,460
INSURANCE - EXECUTIVE LIFE	VI 21	(1,460)
TOTAL (agree to Schedule V, line 22, col.8)		$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,763
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	3,638
TRUST/FRANCHISE/CONTRIB/ETC	2,115
LICENSES & PERMITS	2,344
DUES & SUBSCRIPTIONS	8,990
MGMT CO ALLOCATION	379
TRUST/FRANCHISE/CONTRIB/ETC	(2,115)
Less: Public Relations Expense	(0)
Non-allowable advertising	(1,698)
Yellow page advertising	(1,940)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,476

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CRESTWOOD TERRACE # 0022863 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATIN	1999	$ 3,787	3	$ 1,262	$ 1,262	$ 632	$	$	$	$	$	$
2		2000	2,166	3	361	722	722	361					
3		2001	4,398	3		733	1,466	1,466	733				
4		2002	6,906	3			1,151	2,302	2,302	1,151			
5		2003	9,082	3				1,514	3,027	3,027	1,514		
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 26,339		$ 1,623	$ 2,717	$ 3,971	$ 5,643	$ 6,062	$ 4,178	$ 1,514	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM $7,898**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **YES** If YES, have these costs
been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
of Public Aid during this cost report period. $ **68,985**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **#REF!** Has any meal income been offset against
related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees